

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2013
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00123886.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00122021 completed on 1/14/13.</p> <p>Complaint IN00123886 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 25 & 26, 2013</p> <p>Facility number: 012466 Provider number: 155786 AIM number: 201014060</p> <p>Survey team: Christi Davidson, RN</p> <p>Census bed type: SNF: 35 SNF/NF: 118 Total: 153</p> <p>Census payor type: Medicare: 35 Medicaid: 106 Other: 12 Total: 153</p> <p>Sample: 3</p> <p>Allisonville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Investigation of Complaint IN00123886.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Quality Review completed by Tammy Alley RN on March 1, 2013.	F 000			